CLICK to CLEAR FORM

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being
Community Nutrition Services Section / WIC Program

RETURN COMPLETED FORM TO LOCAL AGENCY:

WIC PROGRAM EXCHANGE OF INFORMATION: Infants and Children

Name of Client: _____ **Date of Birth:** _____

I authorize the exchange of the information below between the WIC Program and my child's Health Care Provider.
Autorizo el intercambio de la siguiente información entre el programa WIC y el proveedor de atención médica de mi hijo.

Parent's/Caretaker's Signature/Firma: _____ Date/Fecha: _____

The following information is to be completed by the Health Care Provider.

1. Client is insured through (check one): ☐ Medicaid ☐ Other ☐ No health insurance ☐ Unknown
2. Document if client is ≤ 24 months of age: Birth Weight _____ Birth Length _____ Weeks Gestation _____
3. Enter date and results of most recent measurements / tests:
   Date: _____ Weight: _____
   Date: _____ Recumbent Length: _____ or Standing Height: _____
   Date: _____ Hemoglobin: _____ or Hematocrit: _____
   Date: _____ Blood Lead: _____ or ☐ Results not yet available
4. Immunization status (check one): ☐ Up-to-Date ☐ Not Up-to-Date
5. Medical conditions and medications:

6. Special instructions for nutritional support or feeding:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ☐ Yes ☐ No

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

The North Carolina WIC Program operates in all 100 counties in North Carolina.
For more information, go to https://www.ncdhhs.gov/ncwic or contact your local WIC Program.
This institution is an equal opportunity provider.

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RETURN COMPLETED FORM TO LOCAL AGENCY:

WIC PROGRAM EXCHANGE OF INFORMATION: Women

Name of Client: _____ **Date of Birth:** _____

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.
Autorizo el intercambio de la siguiente información entre el programa WIC y mi proveedor de atención médica.

Parent's/Caretaker's Signature/Firma: _____ Date/Fecha: _____

The following information is to be completed by the Health Care Provider.

1. Actual or expected date of delivery: _____
2. Pre-pregnancy weight (if available): _____
3. Enter date and results of ***most recent*** measurements / tests:

   Date: _____ Weight: _____

   Date: _____ Height: _____

   Date: _____ Hemoglobin: _____or Hematocrit: _____

4. Obstetric history:

5. Medical conditions and medications:

6. Special instructions for nutritional support or feeding:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ☐ Yes ☐ No

Completed by: _____ **Date:** _____ **Phone No.** _____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

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